CELTERS I OI	TO OF DEFICIENCIES	NATIONAL PROPERTY OF THE PROPERTY OF THE	(7/2) ) (	H TEN E GO	NICEDIA CONT	Laray D. ATE	CLIDATEN.
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 01			LETED
		155747	B. WIN	G		08/08/2	2011
NAME OF I	DDOMDED OD GUDDI IEI	D.	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF PROVIDER OR SUPPLIER			1300 M	ERCER AVE			
WOODC	REST NURSING C	CENTER		DECAT	UR, IN46733		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety C	ode Recertification	K(	0000	Attached is Woodcrest's Pla		
	and State Licer	nsure Survey was			Correction for our annual Lif	_	
		the Indiana State			Safety survey conducted on August 8, 2011.The attached		
	Department of				of correction is our credible	μ μιαι ι	
	I	th 42 CFR 483.70(a).			allegation of compliance.Preparation and/or		
	accordance wi	tri 42 CFR 483.70(a).					
					execution of this plan of		
	Survey Date: (	08/08/11			correction in general, or this		
					corrective action in particula		
	Facility Numbe	er: 000556			does not constitute an admission		
	Provider Numb	per: 155747			or agreement by Woodcrest		
	AIM Number:				the facts alleged or conclusions set forth in the statement of deficiencies. Ths plan of		
	All Nulliber.	100230130					
		W III - 1:5 G G .			correction and specific corre	ctive	
	· ·	y Kelley, Life Safety			actions are preapared and/o		
	Code Specialis	t			executed incompliance with	Life	
					Safety Code.		
	At this Life Saf	fety Code survey,					
	   Woodcrest Nu	rsing Center was					
		ompliance with					
		for Participation in					
	I	· · · · · · · · · · · · · · · · · · ·					
	Medicare/Med						
		0(a), Life Safety					
	from Fire and	the 2000 edition of					
	the National Fi	ire Protection					
	Association (N	FPA) 101, Life Safety					
	· ·	napter 19, Existing					
		ccupancies and 410					
	IAC 16.2.	ccapancies and TIV					
	IAC 10.2.						
	This one story	facility was					
	determined to	be of Type V (111)					
	construction a						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ULM21

Facility ID:

000556

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	A. BUILI		01	ON	(X3) DATE S COMPL 08/08/20	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 MERCER AVE DECATUR, IN46733					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	r	TAG		REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	sprinklered. Th alarm system w	ne facility has a fire with smoke						
	detection in corridors, areas open							
	to the corridors							
		cility has a capacity a census of 116 at						
	the time of this							
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/10/11.							
	The facility was							
	compliance wit							
		s evidenced by the						
	following:							
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 provided in the approve extinguishing system are separated from resisting partitions self-closing and no protective plates the	d construction (with 3/4 hour ran approved automatic fire em in accordance with 8.4.1 otects hazardous areas. It dautomatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches if the door are permitted.						
	Based on obser interview, the f		K00	)29		Whati corrective actior(s) womplished fior tihose reside		09/19/2011
		oll down doors at				tio have been afiectied by ti nti practice	ihe	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **OULM21** Facility ID:

000556

If continuation sheet

Page 2 of 8

I		(X2) M	ULTIPLE CO	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED 08/08/2011
		155747	B. WIN			06/06/2011
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP CODE	
WOODC	REST NURSING C	ENTED		1	ERCER AVE UR, IN46733	
	SUMMARY STATEMENT OF DEFICIENCIES			<u> </u>	OK, 1140733	
(X4) ID				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·	+		In an efiorti tio correcti tihis deficio	<u> </u>
	the openings in the kitchen wall, a hazardous area, would self close				practice, tihe pass tihrough openir	
					in tihe corridor wall betiween tihe	-
	· ·	n of the fire alarm			dining room and tihe kitichen will	
	· ·	deficient practice			have tihe rolling door connectied t	
		residents in the			tihe fire panel so tihe rolling door	will
	main hall dinin	ig room.			close upon activation ofi tihe fire alarm.	
	Findings include:  Based on observation with  Maintenance Technician # 1,  Maintenance Technician # 2,  Maintenance Lead and the			2. How otiher residentis havi	ng	
	Findings include:				tihe potiential tio be afiectied by ti	-
					same deficienti practice will be	
	Based on obse	rvation with			identified and whati corrective	
	Maintenance Technician # 1,				action(s) will be tiaken?	
	Maintenance T	echnician # 2,				
	Maintenance L	ead and the			In an efiorti tio preventi residentis firom being afiectied by tihis defici	
	Environmental	Service Supervisor			practice, tihe deficienti practice ha	
	on 08/08/11 a	ıt 1:35 p.m., the			been correctied by connecting	
	main dining ro	om was open to the			tiherolling door tio tihe fire panel	
	corridor and m	et the requirements			There are no otiher pass tihrough	
		be allowed to be			doors in tihe fiacilitiy	
	· ·	rridor. The wall			3. Whati measures will be pu	
	around the din				intio place or whati systiemic chan will be make tio ensure tihati tihe	ges
		sidered to be the			deficienti practice does noti recu?	
		There was a pass			The deficienti practice cannoti rec	ur
		ng in the corridor			as tihe pass tihrough rolling door h	nas
		he dining room and			been connectied tio tihe fire pane	
		he opening was			and tihere are no otiher pass tihro	ugh
	protected with	•			rolling doors in tihe fiacilitiy	
	Based on inter				4. How tihe corrective action	s)
		view with			will be monitiored tio ensure tihe	
					deficienti practice will noti recur	
		, the rolling door			whati qualitiy assurance programs	will
		upon activation of			be puti intio plac@	
	the fire alarm.				Fire drills are held montihly and closure ofi tihe pass tihrough door	· will
	2.1.10(5)				be monitiored by tihe maintienand	
	3.1-19(b)				22 monaciona by the manufullant	

000556

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPL	E CON	ONSTRUCTION (X3) DATE SURVEY		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		01		COMPLETED	
		155747	B. WIN				08/08/2	011	
NAME OF B	ROVIDER OR SUPPLIER			STR	EET AD	DRESS, CITY, STATE, ZIP CODE			
						RCER AVE			
WOODCREST NURSING CENTER			DE	CATU	R, IN46733				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID			PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•		PREFIX TAG		- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG		•	c:	DATE	
						man montihly tio ensure closure of tihe door when tihe fire alarm is	П		
						activatied Monitioring will be			
						ongoing witih resultis tio QA time			
						montihs			
K0038	Exit access is arra	nged so that exits are							
SS=E		at all times in accordance						08/23/2011	
00 _	with section 7.1.	19.2.1							
	Based on obser	vation and	K0	0038		1. Whati corrective		08/23/2011	
	interview, the f	acility failed to				action(s) will be accomplished fior tihose residenti fiound tio have been affectied by tihe deficienti practice In an efforti tio correcti tihis deficienti			
	ensure exit acc	ess was arranged							
	so 2 of 7 exits	were readily							
	accessible at al	l times in				practice, tiemporary sidewalks hav	re e		
	accordance with LSC Section 7.1.				been instialled leading tio a public				
	LSC Section 7.1	requires that				way firom tihe A and C wing			
	means of egres	s for existing				2. How other reside			
	buildings shall	comply with				having tihe potiential tio be affected by tihe same deficienti practice wil			
	Chapter 7. LSC	Section 7.7.1				be identified and whati corrective	"		
	requires all exi	ts shall terminate				action(s) will be tiaken?			
	-	blic way or at an				No residentis will be afiectied by ti	ectied by tihis		
	•	scharge. Yards,				deficienti practice as tiemporary			
	courts, open sp					walkways are in place leading tio a			
		exit discharge shall				public way and will be replaced win permanenti walkways witihir60 da			
	•	width and size to				3. Whati measures v	•		
		upants with a safe				be puti intio place or whati systiem			
	•	olic way. In addition				changes will be make tio ensure tihati			
		e required width to				tihe deficienti practice does noti			
		ants safe access to				recur?			
	a public way, si					Temporary walkways have been instialled and will be replaced witil	h		
	· ·					permanenti walkway leading tio til			
		the requirements				public way witihin60 days ensuring			
	-	maintaining the				tihis deficienti practice does noti			
	means of egres					recur.			
		at would prevent				4. How tihe correction			
	its use, such as	s snow and the need				action(s) will be monitiored tio ens	sure		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  01		01	COMPLETED			
		155747	B. WIN			08/08/201	1
		II			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1300 M	ERCER AVE		
WOODC	WOODCREST NURSING CENTER			1	UR, IN46733		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re C	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	· · · · · · · · · · · · · · · · · · ·	-	DATE
		in some climates or			tihe deficienti practice will noti rec	· I	
	soft ground du	ring heavy periods			whati qualitiy assurance programs be puti intio place	WIII	
	of rain. This d	eficient practice			No monitioring needed as sidewal	ks	
	could affects a	ll occupants			tio public ways are permanenti on	I	
	evacuated thro	ugh the exits at the			instialled		
	end of both A	and C wings.					
	Findings includ	le:					
	Based on an ob	oservation with					
	Maintenance T	echnician # 1.					
	Maintenance T						
	Maintenance Lo						
		Service Supervisor					
		it 12:15 p.m. and					
		·					
	_	2:55 p.m., due to					
	the construction						
		ving, the sidewalk					
		rom the egress path					
		ne end of both A					
	and C wings.	The excavation of					
	this area has c	reated large					
	mounds of dirt	and holes. The					
	distance from	the public way to A					
	wing sidewalk	is one hundred feet.					
	1	om C wing is sixty					
	feet. Measurements were provided by Maintenance Technician # 1 at the time of						
	observations.	at the time of					
	observations.						
	2.1.10/5)						
	3.1-19(b)						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	(X2) MU A. BUII B. WIN	LDING	01 	(X3) DATE S COMPLI 08/08/20	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
WOODC	WOODCREST NURSING CENTER			1	ERCER AVE JR, IN46733			
(X4) ID		JMMARY STATEMENT OF DEFICIENCIES I DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
IAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	+	IAG	BEITELEVETY		DATE	
K0045 SS=E	discharge, is arran single lighting fixtuarea in darkness. emergency lighting 7.8.) 19.2.8 Based on obser		K	0045	Whati corrective action(s) will be accomplished fior	1	08/23/2011	
area in darkness This deficient pra any number of re visitors evacuated	would not leave the ss at 2 of 7 exits. cractice could affect residents, staff and ted using the exits and of wings A and			tihose residentis fiound tio have be afiectied by tihe deficienti practice In an efiorti tio preventi residentis firom being afiectied by tihis defici practice, constiruction lightisconnectied tio tihe generation will be tiemporarily used fior approximatiely60 days equal tio or fiooti candle tio preventi areas ofi darkness along tihe walkways firor and C wing leading tio tihe public	enti or ne			
	Finding include	:				How otiher residentis		
	Based on an ob	servation with			having tihe potiential tio be affection by tihe same deficienti practice will			
	Maintenance Te	echnician # 1,			be identified and whati corrective			
	Maintenance Te	echnician # 2,			action(s) will be tiaken?			
	Maintenance Le	ead and the			No residenti has tihe potiential tio			
		Service Supervisor			afiectied by tihis deficienti practice walkways have been liti and no oti	1		
		t 12:20 p.m. and			walkways were affectied by tihe			
	then again at 1				constiruction projecti			
		scharge for wings A			3. How other reside			
	· ·	pped with a single			having tihe potiential tio be affection by tihe same deficienti practice will			
	_	th a single bulb.			be identified and whati corrective			
	Based on an int				action(s) will be tiaken?	l		
		echnician # 1 at the			The constiruction lightis are hooke	1		
		ation, additional			tio tihe generatior and tihe perma	nenti		
	lights for these	exit discharge			lighting will be connectied tio tihe generatior whichis selfi tiestied we	ekly		

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	A. BUII	LDING	NSTRUCTION 01	(X3) DATE S COMPL 08/08/2	ETED
		100171	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00,0072	
NAME OF P	ROVIDER OR SUPPLIER			1	ERCER AVE		
WOODC	REST NURSING CE	ENTER		1	UR, IN46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU				IAG	witih fiull load montihly		DATE
	paths were located in the parking lot but due to the addition of the				How tihe corrective action(s) will be	e	
		ving the parking lot			monitiored tio ensure tihe deficien	nti	
		removed in the			practice will noti recur, whati quali	-	
	excavation pro				assurance programs will be puti in place?	itio	
	excavation pro-				The generator is self tested		
	3.1–19(b)				weekly to ensure lights are operating even with loss of power. Documentation will to done by the maintenance mathematical monthly and results to QA tires.	an	
K0130 SS=E	OTHER LSC DEF	ICIENCY NOT ON 2786			months.		
	current inspect ensure the wate safe operating 101, in 19.1.1. facilities to be operated to min possibility of a requiring the en residents. This	acility failed to vater heaters had a ion certificate to er heater was in condition. NFPA 3 requires all health maintained and nimize the fire emergency vacuation of deficient practice y resident near the ical room.	KO	0130	1. Whati corrective action(s) will be accomplished fior tihose residensti fiound tio have be affectied by tihe deficienti practice. In an efforti tio preventi tihis deficientice firom affecting residentists watier heatiers were inspectied or Augusti17 tio ensure safie operation condition.  2. How otiher reside having tihe potiential tio be affectiby tihe same deficienti practice wie be identified and whati corrective action(s) will be tiaker? In an efforti tio preventi residentishe affectied by tihis deficienti practice wie action will be tiaker? In an efforti tio preventi residentishe affectied by tihis deficienti practice ensure safie operating condition. Inspections are currenti in tihe nursing fiacility and maintienace is awaiting tihe certificatie tio be	een eienti tihe n ng entis ied itll tio etice	08/26/2011
	Maintenance Te				emailed.		
	Maintenance Te				3. How tihe corrective	ve	
	Maintenance Le	ead and the			action(s) will be monitiored tio en		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY  COMPLETED  08/08/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 MERCER AVE DECATUR, IN46733						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION	ĺ			
	on 08/04/11 a wing mechanic heater with reg number 26034 of Inspection w 05/26/11. Bas with the Mainte 1 at the time of was unable to p			tihe deficienti practice will not whati qualitiy assurance proge be puti intio place  In an eforti tio preventi tihis practice from recurring, tihe heatiers were placed on tihe schedule.  4. How tihe condition action(s) will be monitioned to tihe deficienti practice will not whati qualitiy assurance proge be puti intio place  The PM schedule will be monomontihly by tihe lead maintiman tio ensure tihe watier hare inspectied and tiheertific indicaties currenti inspection. This QA will be ongoing with tio QA times7 montihs	defcienti watier PM rective io ensure oti recur rrams will nitiored enance eatiers atie n daties				